COMBINED HEALTH REIMBURSEMENT AND DEPENDENT CARE ASSISTANCE PLANS

Adopted January 1, 2005

ARTICLE I.
INTRODUCTION

1.1 Establishment of Plan

The Employer identified in Exhibit A (hereinafter the "Employer") hereby establishes this flexible benefits plan (the "Plan") effective January 1, 2005 (the "Effective Date"). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to permit Eligible Employees to select between Health Flexible Spending Account and Dependent Care Assistance Plan benefits, and to pay for those Benefits with Employee contributions. Employee contributions will be paid on a pre-tax Salary Reduction basis.

1.2 Legal Status

The Health FSA Component of this Plan is intended to qualify as a "self-insured medical reimbursement plan" under Code § 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from the participating Employees' gross income under Code § 105(b). The DCAP Component of this Plan is intended to qualify as a "dependent care assistance plan" under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from the participating Employees' gross income under Code § 129(a).

Although set forth together within this document, the Health FSA Component and the DCAP Component are separate plans for the purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§ 105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of ERISA and COBRA, to the extent applicable.

ARTICLE II.
DEFINITIONS

2.1 Definitions

"Account(s)" means the Health FSA Accounts and the DCAP Accounts described in Sections 7.5 and 8.5, respectively.

"Benefits" means the Employer's Health FSA and DCAP Benefits. The Employer may substitute, add, subtract or revise at any time the menu of such plans and/or the benefits, terms and conditions of any such plans. Any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"Change in Status" has the meaning described in Section 12.3.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as from time-to-time amended.

"Compensation" means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election' under this Plan, (b) any salary reduction election under any other cafeteria plan, and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k) or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box I of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b) or (c) of the prior sentence.

"Contract Administrator" means Fringe Benefits Management Company to whom the Plan Administrator has delegated certain specific administrative responsibilities under this Plan and the Administrative Agreement between the parties.

"DCAP" means the Employer's dependent care assistance program.

"DCAP Account" means the account described in Section 8.5.

"DCAP Benefits" has the meaning described in Section 8.1.

"DCAP Component" means the Component of this Plan described in Article VIII.

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code § 152, with the following exceptions: (a) for purposes of accident or health coverage (to the extent such is an Insured Benefit under the Plan, and for purposes of the Health FSA Component), any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc., where one or both

parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents; and (b) for purposes of the DCAP Component, a dependent means a qualifying individual as defined in Code § 21(b)(1) with respect to the Participant, and in the case of divorced parents, the child shall, as provided in Code § 21(e)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code § 152(e)(1)) and shall not be treated as a qualifying individual with respect to the non-custodial parent. Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"Dependent Care Expenses" has the meaning described in Section 8.3.

"Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include (a) any amounts received pursuant to any DCAP established under Code § 129; or (b) any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation. "Effective Date" of this Plan has the meaning described in Section 1.1.

"Election Form/Salary Reduction Agreement" means the form provided by the Contract Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Health FSA Benefits and/or DCAP Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in Exhibit B. "Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; and (c) any employee covered under a collective bargaining agreement. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer.

"Employer" means the entity identified as Employer in Exhibit A.

"Employment Commencement Date" means the first regularly-scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Health FSA" means the health flexible spending arrangement made a part hereof.

"Health FSA Account" means the account described in Section 7.5.

"Health FSA Benefits" has the meaning described in Section 7.1.

"Health FSA Component" means the Component of this Plan described in Article VII.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Medical Care Expenses" has the meaning defined in Section 7.3.

"Medical Insurance Benefits" means the Employee's Medical Insurance Plan coverage for purposes of this Plan.

"Open Enrollment Period" with respect to a Plan Year means the month occurring two months preceding the start of each Plan Year, or such other period as may be agreed to by the parties.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include those who elect Health FSA or DCAP Benefit and to to pay for same via Salary Reductions.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it will mean the portion of the Plan Year following the date participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it will mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.2.

"Plan" means the Plan as set forth herein and as amended from time to time. "Plan Year" means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31), except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year will be the entire short plan year. Any exceptions to this definition of Plan Year will be set forth in Exhibit C.

"Plan Administrator" means the Employer.

"QMCSO" means a qualified medical child support order, as defined in ERISA § 609(a).

"Qualifying Dependent Care Services" has the meaning described in Section 8.3.

"Qualifying Individual" has the meaning described in Section 8.3.

"Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable benefit, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pretax basis).

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code). Notwithstanding the above, for purposes of the DCAP Component, the term "Spouse" will not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

"Student" means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

ARTICLE III.
ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

Eligibility to participate is set forth in Exhibit B, as from time-to-time amended by the Employer.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

- the expiration of the Period of Coverage for which the Employee has elected to participate (unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating);
- the termination of this Plan;

- the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of pre-taxing COBRA coverage, as may be permitted by the Contract Administrator on a uniform and consistent basis (but not beyond the end of the current Plan Year); or

- the date the Participant revokes his or her election to participate under a circumstance when such change is permitted under the terms of this Plan. Termination of participation in this Plan will automatically revoke the Participant's elections and terminate the benefits as of the applicable dates specified in the insurance Plans. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Sections 7.8 and 8.8.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then is rehired within 30 days or less of the date of a termination of employment, the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction in hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 3.1 before again becoming eligible to participate in the Plan.

3.4 FMLA Leaves of Absence

(a) Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the premium, if any.

A Participant may elect to continue his or her coverage for Health FSA Benefits during the FMLA leave. If the Participant elects to continue coverage while on leave, then the Participant may pay his or her share of the premium in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

- with pretax dollars, by pre-paying all or a portion of the premium for the expected

duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the premium, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

- under another arrangement agreed upon prior to the commencement of leave between the Participant and the Employer (e.g., the Employer may fund coverage during the leave and withhold "catch-up" amounts upon the Participant's return).

If a Participant's coverage ceases while on FMLA leave, the Participant will be permitted to re-enter the Plan upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or otherwise required by the FMLA.

(b) Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, entitlement to Dependent Care Assistance Plan Benefits, is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave (as agreed to by both the Participant and Employer prior to the commencement of leave as described in Section 3.5.)

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the premium due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Employer.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules in Section 12.4 will apply.

ARTICLE IV
METHOD AND TIMING OF ELECTIONS

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year may commence participation on the first day of the month after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Contract Administrator before the first day of the month in which participation will commence. An Employee who does not elect to participate when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 12.4.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, The Contract Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the Benefits of this Plan for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Contract Administrator on or before the last day of the Open Enrollment Period. If an Eligible Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect to participate in this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 12.4.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Section 4.2, then the Employee will receive his or her current benefits from the Employer and nothing else.

Such Employee may not make a different election to participate in the Plan: (a} until the next Open Enrollment Period; or (b} until an event occurs that would justify a mid-year election change, as described under Section 12.4.

4.4 Irrevocability of Elections

Unless an exception applies (as described in Article XII), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE V
BENEFITS OFFERED AND METHOD OF FUNDING

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect from (a) Health FSA Benefits, as described in Article VII; and (b) DCAP Benefits, as described in Article VIII.

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

5.2 Participant Contributions

The Employer shall withhold from a Participant's Compensation on a pre-tax Salary Reduction basis an amount equal to the contributions required from the Participant for the Benefits elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation shall be applied to fund Benefits as soon as administratively feasible. The maximum amount of Salary Reductions shall not exceed the aggregate cost of the Benefits elected. Participants who elect any of the Benefits may pay for their required contributions on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement. The Employer may elect, on a Plan Year to Plan Year basis, to contribute an amount to the Participant's Account for the reimbursement of Eligible Expenses.

5.3 Using Salary Reductions to Make Contributions

(a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual premium for such Benefits (as described in Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, and Section 8.2 for DCAP Benefits), divided by (2) the number of pay periods in the Period of Coverage, or an amount otherwise agreed upon between the Employer and the Participant. If a Participant who is making Salary Reductions increases his or her election under the Health FSA Component or DCAP Component as permitted under Section 12.4, the Salary Reductions per pay period will be equal to (x) the new reimbursement limit elected pursuant to Section 12.4, less the aggregate premiums for the period prior to such election change, divided by (y) the number of pay periods in the balance of the Period of Coverage commencing with the election change.

(b) *Considered Employer Contributions for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the Participant's premiums for the Health FSA Benefits and the DCAP Benefits and, for the purpose of this Plan and the Code, are considered to be Employer contributions.

(c) *Salary Reduction Balance Upon Termination of Coverage.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Contract Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment

of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it has contracted with the Contract Administrator to make Benefit payments on its behalf. The maximum contributions that may be made under this Plan for a Participant is the total of the maximums that may be elected under Sections 7.4(b) and 8.4(b) for Health FSA and DCAP Benefits.

ARTICLE VI
PAYMENT

6.1 Benefits

The benefits that can be elected under the Plan are the Health FSA and the DCAP. Benefits elected will be funded by Participant contributions as provided in Section 5.2.

Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE VII
HEALTH FSA COMPONENT

7.1 Benefits

An Eligible Employee can elect to participate in the Health FSA Component by electing to receive benefits in the form of reimbursements for Medical Care Expenses (Health FSA Benefits). Benefits elected will be funded by Participant contributions as provided in Section 5.2. Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates. The Employer may elect, on a Plan Year to Plan Year basis, to contribute an amount to the Participant's Account for the reimbursement of Eligible Expenses.

7.2 Benefit Premiums (a/k/a Cost of Coverage)

The annual premium for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum annual benefit amount is $2,400 and such amount is elected, then the annual premium amount is also $2,400). The maximum annual benefit amount will be determined by the Employer on a year-to-year basis.

7.3 Eligible Medical Care Expenses

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving

rise to the expense is furnished, and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) *Medical Care Expenses.* "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213 (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs), or otherwise approved by the Internal Revenue Service, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through any other insurance, or any other-accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article.

7.4 Maximum and Minimum Benefits

(a) *Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage" (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VII have been satisfied.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be determined by the Employer on a year-to-year basis, subject to Section 7.5 (c) below. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses is $0.00 per Plan Year. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) *Changes; No Proration.* For each Plan Year, the maximum and minimum dollar limit may be changed by the Employer and Contract Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Health FSA Component mid-year, or wishes to increase his or her election mid-year as permitted under Section 12.4, there will be no proration rule – i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to

the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XII affecting annual contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the aggregate premium for the period prior to such election change to (2) the total premium for the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage.

7.5 Establishment of Account

The Contract Administrator will establish and maintain a Health FSA Account with respect to each Participant who has elected to participate in the Health FSA Component, but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a record keeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

(a) *Crediting of Accounts.* A Participant's Health FSA Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.* A Participant's Health FSA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

(c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements during the Period of Coverage; it is not based on the amount credited to the Health FSA Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Period of Coverage, but any such negative amount shall never exceed the maximum dollar amount of annual benefits elected by the Participant under this Plan.

7.6 Forfeiture of Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: (a) first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to any

Participant in excess of the premiums paid by such Participant through Salary Reductions; (b) second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Contract Administrator); and (c) third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Contract Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.7 Reimbursement Procedure

(a) *Timing*. Within 30 days (or such shorter period as may be contractually agreed to by Employer and Contract Administrator) after receipt by the Contract Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Contract Administrator approves the claim), or the Contract Administrator will notify the Participant that his or her claim has been denied. This time period may be extended for an additional period for matters beyond the control of the Contract Administrator, including cases where a reimbursement claim is incomplete. The Contract Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

(b) *Claims Substantiation*. A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting an application in writing to the Contract Administrator in such form as the Contract Administrator may prescribe, by no later than sixty (60) days following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:

- the person or persons on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement; and
- a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that. the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Contract Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least $25.

(c) *Claims Denied.* For reimbursement claims that are denied; see the appeals procedure in Article XIII.

7.8 Reimbursements After Termination; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant (or the Participant's estate) files a claim no later than sixty (60) days following the close of the Plan Year in which the Medical Care Expense was incurred.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event, shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA), with premiums for such coverage to be paid on an after-tax basis, unless permitted otherwise by the Contract Administrator on a uniform and consistent basis (but not beyond the current Plan Year). Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

7.9 Named Fiduciary; Compliance With ERISA, COBRA, HIPAA, etc.

(a) *Named Fiduciary.* The Employer is the named fiduciary for the Health FSA Component for purposes of ERISA § 402(a), if applicable.

(b) *Laws Applicable to Group Health Plans.* Health FSA Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, etc.

(c) *Coordination of Benefits*. Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health FSA shall not be considered a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

ARTICLE VIII
DCAP COMPONENT

8.1 Benefits

An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses. Benefits elected will be funded by Participant contributions as provided in Section 5.2. Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates.

8.2 Benefit Premiums (a/k/a Cost of Coverage)

The annual premium for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum $5,000 annual benefit amount is elected, the annual premium amount is also $5,000).

8.3 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) *Incurred*. A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) *Dependent Care Expenses*. "Dependent Care Expenses" means expenses that are considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any), and expenses for incidental household services, if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g. because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VIII.

(c) *Qualifying Individual.* "Qualifying Individual" means:

- a Participant's Dependent who is under the age of thirteen (13);
- a Participant's Dependent who is mentally or physically incapable of self-care; or
- a Participant's Spouse who is mentally or physically incapable of self-care.

(d) *Qualifying Dependent Care Services.* "Qualifying Dependent Care Services" means the following services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed:

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's Dependent who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(e) *Exclusion.* Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code § 151 (c) to a Participant or his or her Spouse;
- a Participant's Spouse; or
- a Participant's child who is under 19 years of age at the end of the year in which the expenses were incurred.

8.4 Maximum and Minimum Benefits

(a) *Maximum Reimbursement Available; Statutory Limitations.*

The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 8.5. Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements

of this Article VIII have been satisfied. Notwithstanding the foregoing, no payment otherwise due to a Participant hereunder shall exceed the smallest of:

- the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements for Dependent Care Expenses incurred during the Period of Coverage;

- the Participant's Earned Income for the calendar year;

- the Earned Income of the Participant's Spouse for the calendar year (a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense, and (2) is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount of $[illegible] per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $400 per month); or

- Either (1) $5,000 for the calendar year if one of the following applies:

  (A) the Participant is married and files a joint return;

  (B) the Participant is married, but (1) furnishes more than one-half the cost of maintaining the Dependent for whore the Participant is eligible to receive reimbursements under the DCAP; (2) the Participant's Spouse maintains a separate residence for the last six months of the calendar year; and (3) the Participant files a separate tax return; or

  (C) the Participant is single or is the head of the household for tax purposes;

or

(2) $2,500 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be the maximum amount allowed by law (subject to the other limitations described above, and subject to Section 8.4( ) minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $[illegible]

(c) *Changes; No Proration.* For subsequent Plan Years, the maximum or minimum dollar limit may be changed by the Contract Administrator and shall be communicated to employees through the Election Form/Salary Reduction Agreement or other document that enters the DCAP

Component mid-year, or wishes to increase his or her election mid-year as permitted under Section 12.4, there will be no proration rule – i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XII affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Section 8.4(a). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the aggregate premium for the period prior to such election change to (2) the total premium for the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

8.5 Establishment of Account

The Contract Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 8.6.

(a) *Crediting of Accounts.* A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.* A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) *Available Amount Based on Credited Amount.* As described in Section 8.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements; i.e., it is based on the amount credited to the DCAP Account at a particular point in time. Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

8.6 Forfeiture of Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan may, at the choice of the Employer, be used as follows: first, to reduce the cost of administering this Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Contract Administrator); and second, to provide increased benefits or

compensation to Participants in subsequent years in any fashion the Contract Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the. Period of Coverage in which the Dependent Care Expense was incurred shall be 'forfeited and applied as described above.

8.7 Reimbursement Procedure

(a) *Timing*. Within 30 days after receipt by the Contract Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Contract Administrator approves the claim), or the Contract Administrator will notify the Participant that his or her claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Contract Administrator, including in cases where a reimbursement claim is incomplete. The Contract Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

(b) *Claims Substantiation*. A Participant who has elected to receive DCAP Benefits for a Period of Coverage shall apply for reimbursement by submitting an application in writing to the Contract Administrator in such form as the Contract Administrator may prescribe, by no later than sixty (60) days following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:

- the person or persons on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if an individual); and a statement that such Expenses have not otherwise been paid and are not expected to be paid through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Contract Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least $25.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XIII.

8.8 Reimbursements After Termination

When a Participant ceases to be a Participant as defined under Section 3.2, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements, subject to the following: such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to termination, including expenses incurred in the month following termination if such month is in the current Plan Year, provided that the Participant (or the Participant's estate) files a claim by March 31 following the close of the Plan Year in which the Dependent Care Expense arose.

8.9 Report to Participants

Within 60 days of the close of each plan year, the Contract Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written statement showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the DCAP Component, as the Contract Administrator deems appropriate.

ARTICLE IX. HIPAA PROVISIONS FOR HEALTH FSA

9.1 Effective Date

This Article IX shall be effective as of April 14, 2004. This Article IX shall be interpreted in a manner that permits the Plan to comply with HIPAA and other federal and state laws regarding protection of PHI.

9.2 Use of Protected Health Information

The Health FSA will use and disclose protected health information (PHI), as defined in 45 CFR § 164.501, to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Health FSA will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as defined in the Health FSA HIPAA Privacy Notice (as defined in 45 CFR § 164.520) distributed to Participants (as defined in Section 2.1).

The Health FSA will disclose PHI to the Employer only upon receipt of a certification from the Employer that the Health FSA plan document has been amended to incorporate the provisions in Section 9.2 below and that the Employer agrees to certain conditions regarding the use and disclosure of PHI and the adequate separation between the Health FSA and the Employer and

Related Employers.

9.3 Employer's Obligations With Respect to PHI

With respect to PHI, the Employer agrees to certain conditions. The Employer agrees to:

• not use or disclose PHI other than as permitted or required by the Plan document or as required by law;

• ensure that any agents (including a subcontractor) to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

• not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

• not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

• report to the Plan any PHI use or disclosures of which it becomes aware;

• make PHI available to an individual in accordance with HIPAA's access requirements;

• make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

• make available the information required to provide an accounting of disclosures;

• make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

• if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

9.4 Access to PHI Within Employer

Adequate separation will be maintained between the Plan and the Employer. Only the individuals or classes of employees identified in the Health FSA HIPAA Privacy Notice distributed to Participants in accordance with HIPAA shall have access to PHI. The persons described in the Health FSA HIPAA Privacy Notice may use and disclose PHI only for Plan administration functions

that the Employer performs for the Plan. If the persons described herein or any other employees do not comply with the Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

The Employer shall cooperate with the Plan to correct and mitigate any such noncompliance.

9.5 Privacy Official

The Privacy Official shall be responsible for compliance with the Employer's and the Health FSA's obligations under this Article and HIPAA. Specific rules regarding the Privacy Official follow:

a. *Appointment, Resignation and Removal of Privacy Official.* The Employer shall appoint one or more individuals to act as Privacy Official on matters regarding the Health FSA. The individual appointed as Privacy Official may resign by giving 30 days notice in writing to the Employer. The Employer shall have the power to remove that individual for any or no reason.

b. *Policies and Procedures.* The Privacy Official shall from time to time formulate and issue to Participants and the Employer such policies and procedures as he or she deems necessary for compliance with this Article and HIPAA. No policy or procedure, however, shall amend any substantive provision of the Health FSA. Additionally, such policies and procedures must be accepted by the Contract Administrator.

c. *Privacy Notice.* The Privacy Official shall be responsible for arranging with the Employer, the Contract Administrator and any third-party administrator for the issuance of, and any changes to, the Privacy Notice under the Health FSA.

d. *Complaint Contact Person.* The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this Article and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the Health FSA HIPAA Privacy Notice.

ARTICLE X-XI
[RESERVED]

ARTICLE XII
IRREVOCABILITY OF ELECTIONS; EXCEPTIONS

12.1 Irrevocability of Elections

Except as described in this Article XII, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- participation in this Plan; or
- Salary Reduction amounts.

12.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) *Timing for When New Election Must Be Made.* A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 12.4, as applicable, but only if the election under the new Election Form Salary Reduction Agreement is made on account of and is consistent with the event, and the election is made within any specified time period (e.g., for subsections 12.4(4) through (i), within 30 days of the events described in such subsections).

(b) *Effective Date of New Election.* Elections made pursuant to this Section 12.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 12.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed.

(c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components, see Sections 7.4 and 8.4 respectively.

12.3 Change in Status Defined

A Participant may make a new election upon the occurrence of certain events as described in Section 12.4, including a Change in Status, for the applicable Component. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Contract Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and

under this Plan:

(a) *Legal Marital Status*. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(b) *Number of Dependents*. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status*. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefit plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefit plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements*. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, Student status, or any similar circumstance; and

(e) *Change in Residence*. A change in the place of residence of the Participant or his or her Spouse or Dependents.

12.4 Events Permitting Exception to Irrevocability Rule

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Component of this Plan:

(a) *Open Enrollment Period. (Applies to both Health FSA and DCAP Benefits)*. A Participant may change an election during the Open Enrollment Period in accordance with Section 3.2.

(b) *Termination of Employment (Applies to both Health FSA and DCAP Benefits)*. A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.

(c) *FMLA (Applies to both Health FSA and DCAP Benefits)*. A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4.

(d) *Change in Status (Applies to both Health FSA Benefits as Limited Below, and DCAP Benefits as Limited Below)*. A Participant may change his or her actual or deemed election

under the Plan upon the occurrence of a Change in Status (as defined in Section 12.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may not be made to reduce Health FSA coverage during a Period of Coverage; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage on account of attaining a certain age, etc. The Contract Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency .requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules*. For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 3.2), the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment or legal separation).

(2) *Gain. of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if

coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Contract Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Contract Administrator has reason to believe that the Participant's certification is incorrect.

(3) *Special Consistency Rule for DCAP Benefits.* With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code § 129.

(e) *Certain Judgments, Decrees and Orders (Applies to Health FSA Benefits but Not to DCAP Benefits).* If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires health coverage (including an election for Health FSA Benefits) for a Participant's Dependent child (including a foster child who is a Dependent of the Participant), a Participant may (1) change his or her election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(f) *Medicare and Medicaid (Applies to Health FSA Benefits as Limited Below, but Not to DCAP Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Further, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

(g) *Change in Cost (Applies to DCAP Benefits as Limited Below; but Not to Health FSA Benefits).* For purposes of this Section 12.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA, (2) the HMO and the PPO are considered to be similar coverage, and (3) coverage by another employer, such as a Spouse's

or Dependent's employer, is treated as similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Contract Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Contract Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Limitation on Change in Cost Provisions for DCAP Benefits.* The above "Change in Cost" provisions (Sections 12.4(h)(1)-(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code § § 152(a)(1) through (8), incorporating the rules of Code §§ 152(b)(1) and (2).

(h) *Change in Coverage (Applies to DCAP Benefits, but Not to Health FSA Benefits).*

The definition of "similar coverage" under Section 12.4(h) applies also to this Section 12.4(h).

DCAP Coverage Changes. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may Change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider-because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

12.5 Election Modifications Required by Contract Administrator

The Contract Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Contract Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Contract Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the

class who had elected the highest Salary Reduction amount, continuing with the Participant in the class who had elected the next highest Salary Reduction amount, and so forth, until the defect is corrected.

12.6 Overall Limitation on Changes in Contribution Amounts.

No Participant will be allowed to reduce his or her election for a Medical Expense Flexible Spending Account or Dependent Care Flexible Spending Account to a point where the total allotment for the Plan Year for such benefit is less than the amount already reimbursed for that Plan Year. In addition, any change in an election affecting the Participant's annual allotments to such plans pursuant to this section also will change the Participant's benefits for the period of coverage remaining in the Plan Year. The Participant's benefits following an election change will be calculated by adding any balance (including a negative balance) remaining in the Participant's Medical Expense Flexible Spending Account or Dependent Care Flexible Spending Account as of the end of the portion of the Plan Year immediately preceding the change in election, to the total allotments scheduled to be made by the Participant during the remainder of such Plan Year to each account, respectively.

ARTICLE XIII
APPEALS PROCEDURE

13.1 Procedure If Benefits Are Denied Under This Plan. If (a) a claim for reimbursement under the Health FSA or DCAP Components of the Plan is wholly or partially denied, or (b) a Participant is denied a benefit under the Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to coverage under the Plan (for example, a determination of: a Change in Status; or eligibility and participation matters under the Flexible Benefits Plan Document), then the claims procedure described below will apply.

A. *Notification.* If a claim is denied in whole or in part, the Participant will be notified in writing by the Contract Administrator within 30 days of the date the Contract Administrator received the claim. (This time period may be extended for circumstances beyond the control of the Contract Administrator, including in cases where a claim is incomplete. The Contract Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Contract Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on the claim until the specified information is provided.)

B. *Notification Requirements.* Notification of a denied claim will set out:

- a specific reason or reasons for the denial;

- the specific Plan provision on which the denial is based;

- a description of any additional material or information necessary to validate the claim and an explanation of why such material or information is necessary;

- appropriate information on the steps to be taken to appeal the Contract Administrator's decision, including the right to submit written comments and have them considered, the right to review (upon request and at no charge) relevant documents and other information, and, if applicable, the right to file suit under ERISA with respect to any adverse determination after appeal of the claim.

C. *Appeals by Participant.* If the claim is denied in whole or part, the Participant (or his or her authorized representative) may request review upon written application to the Committee (the Appeals Committee that acts on behalf of the Plan with respect to appeals). The appeal must be made in writing within 180 days of receipt of the notice that the claim was denied. If the Participant fails to appeal on time, he or she will lose the right to appeal the denial and the right to file suit in court. The written appeal should state the reasons that the claim should not have been denied. It should include any additional facts and/or documents that support your claim. The Participant will have the opportunity to ask additional questions and make written comments, and may review (upon request and at no charge) documents and other information relevant to the appeal.

D. *Decision on Review.* The appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives the request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

   a. the specific reason(s) for the decision on review; and

   b. the specific Plan provision(s) on which the decision is based;

ARTICLE XIV
RECORDKEEPING AND ADMINISTRATION

14.1 Contract Administrator

The administration of this Plan shall be under the supervision of the Contract Administrator. It is the principal duty of the Contract Administrator to see that this Plan is carried out, in accordance

with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

14.2 Powers of the Contract Administrator

The Contract Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Contract Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Contract Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 14.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Contract Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Contract Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Contract Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review and Keep on file such reports and information concerning the benefits covered by this Plan as the Contract Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems

necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

The Contract Administrator may rely upon the direction, information or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Contract Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Contract Administrator.

14.4 Provision for Third-Party Plan Service Providers

The Contract Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

14.5 Fiduciary Liability

To the extent permitted by law, the Contract Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

14.6 Compensation of Plan Contract Administrator

Unless otherwise determined by the Employer and permitted by law, any Contract Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of then duties shall be paid by the Employer.

14.7 Bonding

The Contract Administrator shall be bonded to the extent required by ERISA.

14.8 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan

but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

14.9 Inability to Locate Payee

If the Contract Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

14.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Contract Administrator shall, to the extent it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Contract Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XV
GENERAL PROVISIONS

15.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Sections 7.6 and 8.6, and then by the Employer.

15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for

any reason by resolution of the appropriate authority to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

15.4 Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of Florida to the extent not superseded by the Code, ERISA or any other federal law.

15.5 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. (ERISA may apply to the Health FSA Component but not to the DCAP Component.) This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

15.6 No Guarantee of Tax Consequences

Neither the Contract Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Contract Administrator if the Participant has any reason to believe that such payment is not so excludable.

15.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a pre-tax Salary Reduction basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur-for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

15.8 Confidentiality and Security Statement

Employer will safeguard, in accordance with standards of security and confidentiality, any information collected, received or maintained about Leon County Board of County Commissioners employees. Employer maintains administrative, technical and physical safeguards to ensure the security and confidentiality of its employee's information and records; to protect against anticipated threats or hazards to such records; and to protect against unauthorized access to or use of such information or records.

Employer limits access to its employees' information only to those persons who need access to the information to perform their job functions. Employees who misuse such information are subject to disciplinary actions up to and including termination. Employer does not disclose employee information to any third parties unless the person is authorized or required or permitted to receive such information by law.

15.9 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

15.10 Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

15.11 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

15.12 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

IN WITNESS WHEREOF, Employer has caused this Plan to be executed in its name and on its behalf, on this _____ day of _____, 200__.

LEON COUNTY, FLORIDA

By:_____
Cliff Thaell, Chairman
Leon County Board of County Commissioners

ATTEST:

By:_____
Bob Inzer, Clerk of the Court
Leon County, Florida

APPROVED AS TO FORM:

By:_____
Herbert W. A. Thiele, Esq.
County Attorney

FRINGE BENEFITS MANAGEMENT COMPANY

By:_____

James Snyder, Senior Vice President

EXHIBIT A
NAME AND ADDRESS OF EMPLOYER/PLAN

Leon County Board of County Commissioners

EXHIBIT B
DEFINITION OF ELIGIBLE EMPLOYEE

All regular full-time employees and any part-time employee with two (2) or more years of service and who work at least 20 hours per week.

EXHIBIT C
PLAN YEAR

The Plan Year for these Plans shall be the period commencing the 1st day of January continuing through December 31st next following.

EXHIBIT D
EXCLUDED EXPENSES

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